Clear Form

SKILLED NURSING VISIT NOTE

SG Patient's Safety Goal

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

PATIENT NAME - Last, First, Middle Initial | ID#

DATE OF VISIT _____

TIME IN _____ AM/PM OUT _____ AM/PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance / device to ambulate ☐ Medical restrictions ☐ Contusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dyspnea on minimal exertion ☐ Bed / Chair bound ☐ Residual weakness ☐ Dependent upon adaptive device(s) ☐ Acute episodes of hyper/hypoglycemia yield unsafe ambulation ☐ Unable to drive ☐ Severe SOB, SOB upon exertion ☐ Other (specify) _____

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T _____ Wt _____ BS _____

Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

☐ Fluid Retention
☐ Chest Pain
☐ Neck Vein Distension
☐ Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
☐ Ascites
☐ Peripheral Pulses
☐ Arrhythmia
☐ Other:
☐ No deficit

RESPIRATORY

☐ Rales ☐ Ronchi ☐ Wheeze
☐ R. Lung ☐ L. Lung
☐ Cough ☐ Sputum
☐ Dyspnea ☐ SOB
☐ Orthopnea
☐ 02. LPM: VIA:
☐ No deficit ☐ Fire Prevention followed SG

DIGESTIVE

☐ Bowel Sound:
☐ Nausea ☐ Vomiting
☐ Anorexia ☐ NPO
☐ Epigastric Distress
☐ Difficulty Swallowing
☐ Abdominal Distention
☐ Colostomy ☐ Ileostomy
☐ Bowel Incontinence
☐ Constipation ☐ Impaction ☐ Diarrhea
☐ Diet:
☐ Fluid Intake:
☐ Enteral Feeding Route:
☐ Type: Amount:
☐ Via:
☐ Flushing:
☐ Appetite ◯ Good ◯ Fair ◯ Poor
☐ LBM: ☐ No Deficit

GENITOURINARY

☐ Burning ☐ Dysuria
☐ Distension ☐ Retention
☐ Frequency ☐ Urgency ☐ Hesitancy
☐ Hematuria
☐ Bladder Incontinence
☐ Catheter ☐ Ileoconduit
☐ Suprapubic Catheter
☐ Foley Catheter
☐ Size Fr. cc.
☐ Last Changed:
☐ Irrigation cc / nsa
☐ Urine
☐ Output cc / hr.
☐ Color
☐ Consistency
☐ Odor
☐ Pain ☐ Discharge
☐ Cath. Leakage ☐ Dislodge
☐ Other
☐ No Deficit

SKIN

☐ Warm ☐ Dry ☐ No Deficit
☐ Cold ☐ Clammy
☐ Jaundice ☐ Pallor ☐ Cyanosis
☐ Turgor ☐ Hydration
☐ Rash ☐ Itching ☐ Discoloration
☐ Decubitus ☐ Wound ☐ Ulcer
☐ Chills
☐ Integrity
☐ Tube Insertion Site
☐ Other

ENDOCRINE

☐ Weakness ☐ Fatigue ☐ Tired ☐ No Deficit
☐ Sign/Symptoms of ☐ Polydipsia ☐ Polyphagia
☐ Sign/Symptoms of ☐ Hyperglycemia ☐ Hypoglycemia
☐ Other

MUSCULOSKELETAL

☐ Balance ☐ Unsteady gait ☐ Endurance
☐ Weakness ☐ Ambulates with Assistance
☐ Limited Movement ☐ Rom
☐ Chair Bound ☐ Bed Bound
☐ Contracture ☐ Paralysis
☐ No Deficit

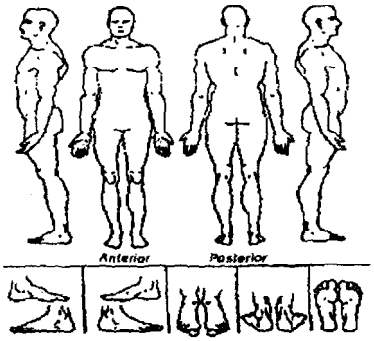
NEUROSENSORY

☐ Syncope
☐ Headache
☐ Grasp ☐ Equal ☐ Unequal
Right: _____
Left: _____
☐ Movement
☐ RUE ☐ LUE
☐ RLE ☐ LLE
☐ Pupil Reaction
☐ Right ☐ Left
☐ Hand Tremors
☐ Poor Hand-Eye coordination
☐ Poor Manual Dexterity
☐ Speech impairment
☐ Hearing Impairment
☐ Visual Impairment ☐ Blindness
☐ Tactile Sensation
☐ No deficit

EMOTIONAL STATUS

☐ Oriented ☐ T ☐ P ☐ P
☐ Forgetful ☐ Confused
☐ Disoriented ☐ T ☐ P ☐ P
☐ Lethargic ☐ Semi Lethargic
☐ Comatose
☐ Restless ☐ Agitated
☐ Anxious ☐ Depressed
☐ Other
☐ No Deficit

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN / FALL MANAGEMENT SG

Frequency of pain interfering with patients activity or movement:
◯ 0 - Patient has no pain
◯ 1- Pain does not interfere with activity or movement
◯ 2 - Less often than daily
◯ 3 - Daily, but not constantly
◯ 4 - All of the time
☐ Pain Management Teaching to patient / family

Intensity 0 1 2 3 4 5 6 7 8 9 10
Low High

Current pain management & effectiveness: ☐ No deficit / Pain

Progress toward pain goal: _____ Patient's pain goal: _____

Primary Site(s): _____

Client is at risk for falls ◯ yes ◯ no **Fall assessment conducted** ◯ Yes ◯ N/A

Potential for falls: 0 1 2 3 4 5 6 7 8 9 10

Potential for falls has: Increased ◯ decreased ◯ SG

Compliant with fall prevention plan: ◯ Yes ◯ No ◯ N/A

INTERVENTIONS / INSTRUCTIONS

☐ Skilled Observation / Assessment
☐ Foley Change ☐ Foley irrigation
☐ Wound Care ☐ Dressing Change
☐ Prep. / Admin. Insulin: _____
☐ SQ Injection: _____ Site: _____
☐ IM Injection: _____ Site: _____
☐ Diabetic Observation / Care
☐ Observation / Inst Med. (N or C) effects / Side Effects _____
☐ Inst. Fall Prevention ☐ Emergency Prepar. SG
☐ Inst. Disease Process _____
☐ Diet. Teaching _____
☐ Safety Precautions/Factors Management Conducted
☐ Teach Infant / Childcare
☐ Peg / GT Tube Site Care
☐ Tracheostomy Care ☐ Suctioning

TECHNIQUES USED

☐ Universal Precautions/ Handwashing Tech. followed
☐ Aseptic Tech.used / Infection Control followed SG
☐ Quality Control of Glucometer Performed as per Agency P & P on: _____
☐ Glucometer Calib. on: _____
☐ Soiled Dressings Double Bagged
☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE: _____

☐ IV Tubing Change
☐ Cap Change ☐ Venipuncture/Lab: _____
☐ Central Line Dressing Change
☐ IV Site Dressing Change
☐ IV Site Change
☐ Infusion by _____ Pump
☐ Infusion Med: _____
☐ Infusion Rate: _____
Comments: _____
☐ Infusion Well Tol. by Pt.

SKILLED INTERVENTION - TEACHING - Pt. RESPONSE

DME/SUPPLIES: ☐ Gloves ☐ Thermometer ☐ BP cuff ☐ Glucometer ☐ Alcohol pads ☐ 4x4 ☐ Sharp container ☐ Other:

PLAN FOR NEXT VISIT:

OTHER PROGRESS TOWARDS GOALS: ☐ PT / S.O. / CG verbalized understanding of inst. given ☐ Other: _____

☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on **DISCHARGE PLANNING DISCUSSED?** Yes ◯ No ◯ N/A ◯

☐ Patient unable to perform own W/C due to: _____

☐ No S.O. or C/G able / willing for Inj. Adm. at this time ☐ Treatment well tolerated by Patient
☐ No S.O. or C/G able / willing for wound care at this time. ☐ Verification of Procedure Performed SG

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved
☐ PRN Order Obtained: _____
☐ Verification of Medication Performed Prior to Admin. SG
MEDICATION STATUS ☐ No Change ☐ Order Obtained: _____
SUPPLIES USED: _____

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN ☐ C.M ☐ HHA ☐
☐ Other: _____

NURSE SIGNATURE / PRINT NAME **RN / LPN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___